

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003290

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED JAN 31 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4111 East Lee Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>E.</b> Last <b>Burroughs</b>		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1963</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Small Arms Plant</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
13a. FATHER'S NAME <b>Edward Betzer</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT Address <b>Eugene W. Burroughs, Sr., 4111 E. Lee Ave</b>		14. NAME OF HUSBAND OR WIFE <b>Eugene W. Burroughs, Sr.</b>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebellar hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <b>Cerebral atherosclerosis</b> <b>Hypertensive vascular disease</b> DUE TO (b) <b>[REDACTED]</b> DUE TO (c) <b>[REDACTED]</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>unk.</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive vascular disease</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>331x</b>	
20c. TIME OF INJURY Hour <b>[REDACTED]</b> a.m. <b>[REDACTED]</b> p.m. <b>[REDACTED]</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>[REDACTED]</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>Aug 10, 1959</b> to <b>Jan 25, 1963</b> and last saw her alive on <b>Jan 25, 1963</b> Death occurred at <b>6:45 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Joseph V. Ferguson M.D.</b>		22b. ADDRESS <b>634 N Grand</b>	22c. DATE SIGNED <b>Jan 25, 1963</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 28, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 26 1963</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
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4 1  
5 1  
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91

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Julius R Brown

Licensed Embalmer No. 5146

P. O. Address St Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.